STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	292501	A. BUILDING _____ B. WING _____	08/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS DIALYSIS CENTER	3100 W CHARLESTON 100 LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the results of the Medicare re-certification survey and complaint investigation completed at your facility on 8/20/08. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting and criminal or civil investigations, actions, or other claims from relief that may be available to any party under applicable federal, state, or local laws. The census at the time of the survey was 198. 15 patient records were reviewed. 4 patient interviews were conducted. 2 complaints were investigated: NV18783 was substantiated, see TAG V265. NV18684 was not substantiated. The following deficiencies were noted:	V 000		
V 232	405.2139(a) MEDICAL RECORDS: PATIENT ASSESSMENTS All medical records contain documented evidence of assessment of the needs of the patient. This STANDARD is not met as evidenced by: Based on record review the facility failed to provide evidence of an assessment of the social services needs for 3 of 15 patient records reviewed. Findings include: There was no evidence in the patient records for patients #10, #3 and #6 that a social services	V 232		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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V 232	Continued From page 1 assessment had been conducted. Likewise, the care plan did not contain a signature in the social worker line, to indicate that social services were involved with the plan of care for these patients. Patient #10 was admitted for services on 3-14-08. Patient #3 was admitted for services on 5-19-08. Patient #6 was admitted for services on 7-4-08.	V 232		
V 265	405.2140(b) PE: FUNCTIONAL/SANITARY /COMFORTABLE The facility is maintained and equipped to provide a functional, sanitary and comfortable environment with an adequate amount of well-lighted space for the service provided. This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain a sanitary and comfortable environment with respect to the clinical furniture. At least 12 of the 38 recliner chairs available for patients during hemodialysis were observed to have visible tears in the material covering the surface of the back and/or seat cushions. Most of the tears observed ranged from 3 inches to 12 inches in length. The surfaces of many of these damaged cushions had been taped in an attempt to repair the tears. On some chairs, the tape had worn off and the surface of the material covering the cushions had a slightly sticky residue. Complaint NV18783	V 265		